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"There was something magical about this group": Building Cohesion in a Psychiatric Hospital

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Capstone Thesis

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Expressive Arts Therapy

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Abstract

This capstone details the development and implementation of Hope Notes, an expressive arts therapy intervention used in a private psychiatric hospital setting. Hope Notes was carried out in the group setting with adolescent and adult clients in a partial-hospitalization or inpatient hospitalization with a range of diagnoses and symptoms including, but not limited to, depression, anxiety, bipolar disorder, schizophrenia, trauma disorders including post-traumatic stress, and obsessive-compulsive disorder with symptoms of delusions, hallucinations, suicidality and homicidally. Using expressive arts therapy the clients worked together to collaboratively discuss, create, design, and build an art piece intended to increase group cohesion and connection on the unit. This directive allowed participants to engage in appropriate socialization, artistic expression, and helped facilitate group cohesion through the creative process as reported by treatment teams of the participants, and Rehabilitation staff members.

Keywords: expressive arts therapy, psychiatric care, adolescents, adults, rehabilitation

"There was something magical about this group"[1]: Building Cohesion in a Psychiatric Hospital

The topic under investigation is the use of expressive arts therapy to build social and emotional connections between clients in an acute-care inpatient psychiatric hospital. The above quote was feedback provided by a client who participated in an expressive arts therapy group during an acute care hospitalization (Chiu, Hancock, & Waddell, 2015). At my current internship I interact with clients diagnosed with severe mental illnesses including, but not limited to: bipolar disorder, schizophrenia, schizoaffective, depression, substance abuse, addiction, a variety of personality disorders and side effects of detoxification in clients between the ages of 13 and 65.

The role of facilitating group cohesion from an expressive arts perspective looks like clients becoming interested in each other's stories, sharing their own experiences, supporting each other through the group process, engaging in creativity, and feeling comfortable in the group space including sharing their reflections with the group. It is my stance that the expressive arts provide a supportive avenue to foster group cohesion. An additional benefit to a cohesive group is the opportunity for clients to feel supported and less alone as they focus on recovery during their hospitalization.

During my time as a rehabilitation and expressive arts therapy intern it became clear to me that many clients felt isolated even in the group environment. The overall idea is to develop a method that may be adapted to each different unit of the hospital (dual diagnosis, partial hospitalization, and detoxification each for adults or adolescents) which may assist in the production of a sense of community and group cohesion.

[1] Chiu, G., Hancock, J. & Waddell, A. (2015). Expressive arts therapy group helps improve mood state in an acute care psychiatric setting. *Canadian Art Therapy Association Journal*, *28*(1–2), 40.

This topic of social connection and community building is important for clients in an inpatient setting as they are away from any supports that may exist outside of the hospital and are forced to acknowledge new supports at the facility. While the support of staff such as the nurses, doctors, social workers, and mental health counselors is essential it is also necessary to identify the value of lived experience and true empathy provided by other clients. For those who are able to recognize the aspects of life they share in common it has the potential to be a powerful experience. In a study by Teglbjaerg (2011) clients reported "I have learned to know others in a way I never could have learned to know somebody else, through the art" (p. 316). Specifically, for my clients, I hoped to learn how I can best foster a sense of community, connection, and support in the group setting.

Literature Review

The task of increasing social connections and group cohesion in a psychiatric hospital is no small feat. However, with previous research collected on stereotypes of psychiatric patients, the connection to trauma, recovery themes, and isolation reduction there is hope for development of a method to promote connection. As the following review of the literature will display allowing for clients to interact with art in a trauma informed practice has the potential to improve mood and promote social connection to the therapist, but more importantly to other clients who may be able to relate about similar lived experiences.

Creativity and Severe Mental Illness

"Following deinstitutionalization and the emptying of the large psychiatric hospitals…many psychiatric patients now face social isolation and stigmatization in the community" (Leichner, Lagarde, & Lemaire, 2014, p. 90). With the history of severe mental illness and its isolative nature engaging with those in a psychiatric hospital allowed for the

opportunity to socially connect and provide support. In addition, the use of art in this setting has proven to be beneficial as well. "Engaging in the arts has been found to improve self-esteem, self-understanding, and interpersonal communication" (Leichner, Lagarde, & Lemaire, 2014, p. 90). Due to the reported history of psychiatric patients experiencing isolation due to closing institutions, as well as the nature of mental illness, the necessity for connection between patients suffering from severe mental illness has grown.

Spaniol (2001) collected interviews from visual artists with clinically diagnosed mental illnesses (five with mood disorders and four with histories of schizophrenia) and asked them to describe their process before, during, and after making art. The interviews with artists revealed the purpose for making art was "self-understanding, self-expression, and self-healing" (Spaniol, 2001, p. 227). Based on the interviews with artists Spaniol reported "it appears possible that there is a relationship between artistic creativity and mental illness…it may be that the connection is related to a person's natural striving for emotional wellness, not their psychopathology" (p. 230). While it may be understood that there is a connection between those who suffer from mental illness and creative expression it may be identified that art was used as a coping mechanism for the individuals interviewed. This idea that a coping mechanism can exist in artwork is the basis for the expressive arts and the use in a psychiatric setting. Clients enter the hospital often with little understanding of what can exist as a coping skill and demonstrating through the group process that art can be a coping skill, as Spaniol's (2001) interviewee mentioned facilitated "self-expression" (p. 227).

Ludwig (1998) designed a study to identify the connection between professional creativity and mental illness using Mandelbrot's fractal theory of self-similarity and connection. "On almost all measures of psychopathology, visual artists with expressive/emotive styles have

the highest lifetime prevalence of alcoholism, drug use, and depression" (Ludwig, 1998, p. 99). Ludwig's research concluded that "those who are more emotionally stable are more inclined than those less stable to gravitate toward professions that encourage more rational forms of expression" (Ludwig, 1998, p. 100). While the researcher was able to establish a connection between professional creativity and mental illness it can also be assumed that those who are not in creative professions can also benefit from the therapeutic use of visual art.

A common misconception about work done by expressive arts therapists is that we create a full diagnosis or analysis of a client's artwork from one observation. "There seem to be no characteristics of a painting or sculpture that allow the physical to assign a psychiatric diagnosis to the artist" (Lejsted & Nielsen, 2006, p. 510). This statement allows space for therapists to safely engage in the arts with psychiatric clients keeping in mind that "there is a complex balance between proper drug therapy and artistic activity" (Lejsted & Nielsen, 2006, p. 511). It is also a reminder that while there may be patterns in art created by those with a specific diagnosis, the art of an individual may not be used to create a diagnosis. Clients learning that expressive arts therapists are not present to make a diagnosis based off of their art can also prove to be comfort in the group setting. Sharing that we as expressive arts therapists are there to provide time for self-reflection and creativity appears to be soothing to many clients.

The transformation of a collection of individuals into a cohesive group is directly related to the work McNiff (1974) explored between "how art therapy can encourage artistic growth, and sometimes more general integration of personality" (p. 12). Allowing an individual the time and opportunity to create a piece of art in a group setting allows for each client to approach their recovery together as they are also coping with internal struggles during treatment. "Instead of attributing Priscilla's [psychiatric patient] artistic production to psychopathological factors, one

could argue that her intensely expressive arts is a manifestation of personality strength" (p. 12). It is possible that individuals diagnosed with severe mental illness use creativity to cope with the workings of their mind, however, the opportunity to take a strengths-based, group approach to art and mental illness allows for clinicians to identify foundational areas of functioning on which to develop therapeutically through art.

Trauma Impacting Psychiatric Patients

One major factor impacting the lives of clients in psychiatric hospitals is the presence of trauma history. Floen and Elklit (2007) reported

> The prevalence of trauma exposure among psychiatric populations has been found to be higher than in the rest of the population. Five studies have reported childhood and sexual abuse in between 34% and 81% of patients with severe mental illness. (para. 1)

With this information it is essential for those working in a psychiatric hospital to also participate in trauma-informed practices. Entering a group setting with the knowledge that a significant percent of the clients have potentially experienced trauma allows an expressive arts therapist to provide appropriate directives, as they "tap into several senses simultaneously, helping to connect with parts of self not readily available in traditional talk therapy" (Perryman, Blisard, & Moss, 2019, p. 83). One challenge of working with those who have experienced trauma is the lack of connection to sense, or desensitization, as a protective factor. Using a multi-modal approach (including visual art, music, drama, poetry, etc.) a therapist has the chance to engage in the senses of a client in a strategic manner, so the client is not overwhelmed. In addition, "creative arts techniques offer both client and counselor a mechanism to remain within the window of tolerance for a longer period allowing the integration necessary for healing" (Perryman, Blisard, & Moss, 2019, p. 85). The window of tolerance is an important topic in

trauma work because it is the space in which the client still feels safe while experiencing a new feeling or sensation, also stated as "a span of tolerance in which we can function optimally, enabling clients to delve into their trauma narrative, without feeling overwhelmed" (Perryman, Blisard, & Moss, 2019, p. 85). This *window of tolerance* is also contained in the holding space of group therapy in a psychiatric setting and extends the invitation to a client to create in a period of non-judgement. Providing clients the opportunity to shift modalities in a session may also help access different senses, for example, visual art and music versus visual art alone. Allowing for a client to engage in their own self-expression in a group setting allows for them to engage with sounding boards or with those who have experienced similar life circumstances. The prevalence of psychiatric patients who have experienced trauma alone is enough for clients to begin to see they are not isolated in their experiences or recovery and speaks to the need for expressive arts as a modality that can meet clients where their window of tolerance may not include traditional talk therapy.

Mood Improvement

One intrinsic goal therapists may identify is allowing clients to assess and potentially adjust moods during group or individual sessions. Granted, it is not a guarantee that a client's mood will change as the result of a therapeutic encounter, it is a general hope for expressive arts therapists that clients will leave the interaction improved in some form. De Petrillo and Winner (2012) conducted a study reporting that "art making appears to enhance mood valance even for those with no special interest or ability" (p. 210). After comparing two study groups—those allowed to create their own art after observing distressing images and those asked to trace line patters after the same observations—data collected using the Affect Grid Assessment demonstrated that "art making appears to enhance mood valance even for those with no special

interest or ability in art" (p. 210). This data can potentially be generalized to psychiatric patients as the field of expressive arts therapy does not require clients to have talent or specific interest in the arts, rather, an open mind about creativity in order to improve general mood state. Regularly in groups clients will mention that they are not an artist, or they have no talent for art. This is important to note as, even those who attempt to participate can still benefit from making art.

Additional studies have been conducted pertaining to the use of art to improve psychiatric patient's mood during their hospitalization. Chiu, Hancock, and Waddell (2015) conducted a study at the Toronto General Hospital which allowed clients to participate in an open Expressive Arts studio. The idea was to allow any clients of the psychiatric unit to "participate in their own way" (p. 35) as well as to administer the Profile on Mood States-Brief (POMS-B) before and after creating art. Reported results included "significant [overall] improvement in Total Mood Disturbance…improvement in mood disturbance can reflect a reduction in negative mood states or an increase in positive mood states" (p. 40). One implication of this research is the inclusion of an open-studio model to improve general mood for psychiatric patients. The impact of a mood change while in a psychiatric hospital can impact length of stay in some cases as I have observed during my psychiatric hospital internship. Those who are willing to engage in groups, treatment team meeting, and the full recovery process also have a chance to be impacted by art making as the previous results have reported by Chiu, Hancock, and Waddell (2015). However, this study was conducted using primarily visual art in the expressive arts therapy and there are also benefits to additional modalities, such as music therapy (citation).

Recovery from Mental Illness

Kooji (2009) found that for those suffering from severe mental illness who have the opportunity to engage in long term work with a music therapist, it is possible to identify themes

in songwriting that have the potential to impact treatment planning and treatment goals of each client. For three patients suffering from severe mental illness themes identified as "dimensions involved in recovery: self, others, the system, and the problem" (Kooij, 2009, p. 41). These themes also bring to light the idea that recovery from severe mental illness does not happen in isolation; moreover, it takes a network of support and identification of a central issue in order for healing to begin. It was also reported "clinical outcomes of songwriting as a therapeutic intervention have included increased self-esteem, increased anger management and anxiety management skills, and increased social interaction" (Kooij, 2009, p. 39). This further supports the assertion that recovery with severe mental illness not only happens with social support and art making, but can also increase social interaction along with other positive improvements to self.

In a separate study, Griffith and Bauer-Leffleur (2018) asked psychiatric hospital staff and patients to define a healthy mind as part of an anonymous and collaborative artwork for display. It was reported that common themes of a healthy mind included "introspection, physicality, and socialization and the need for other people" (Griffith & Bauer-Leffler, 2018, p. 46). The art directive was designed to demonstrate the collaborative effort of staff and patients working toward stability by "anonymously responding to the prompt 'A healthy mind is…' which was chosen to facilitate a qualitative analysis of patients' perceptions of recovery" (p. 43). Providing patients the opportunity to share their idea of healthy mind definitions allowed the hospital staff to better cater to the needs of clients and add to treatment goals. The healthy mind definitions of "socialization and the need for other people" (p. 46) are significant supports to the idea of using art to find a sense of community and cohesion for clients.

Isolation Reduction and Social Connection

Social connection through music can be seen at large scale events such as concerts and those connections can also be boiled down to the therapeutic relationship in music therapy. A proposal was written by Gold et al. (2005) to assess "low therapy motivation and a willingness to work with music to reduce [client's] level of negative symptoms" (p. 2). These researchers proposed the use of resource-oriented music therapy to identify "the client's resources, strengths and potentials, rather than [focusing] primarily on problems and conflicts, and emphasizes collaboration and equal relationships" (p. 2) during session progression. While this proposal has no currently reported results it emphasizes the work being done to identify low therapy motivation and isolation in psychiatric clients where further work is necessary.

In addition to music, the concept of combining art and social connection in a psychiatric hospital has been researched for decades and in several studies results have shown a positive correlation between the two variables according to Teglbjaerg (2011), as well as Testa and McCarthy (2004). Teglbjaerg (2011) evaluated the process of painting weekly with clients suffering from severe mental illness post-inpatient hospitalization. The author reported interviewing the clients before the start of a year, at the end of the year together, and one year after the closing of the group to find "the process of painting made it possible for the patients to be on their own with their paintings and still have a sense of connectedness" (p. 317). This example of art-making in a group setting provides information about the use of creation as a current on which group connection may be carried. Automatically, clients are given a commonality between each of them and further connection may be developed from this starting point.

Creation, however, is not limited to individual paintings and can be expanded to large scale pieces such as murals. Testa and McCarthy (2004) reported that the weekly design and

painting of the mural with three adolescent male clients provided a "framework for the group that served as a catalyst for discussion of group members' feelings" (p. 38). The authors also stated their reflections of the client's creating connections with one another by opening up about fears of discharge while painting and encouraging each other to continue working to feel better demonstrating the clients' learned use of painting as a coping skill and safe space to communicate with each other.

The goal of this writing is to clearly identify the need for facilitated group cohesion in a psychiatric setting. This research has been developed in order to best suit clients suffering from severe mental illness with trauma history to reduce isolation and engage in the collaborative group art-making process. In turn, a positive outcome would be evidenced by group facilitation resulting in clients finding the ability to share their creations as well as work together appropriately to not only communicate their wishes for the artistic design as well as develop relationships with those who may have shared similar life experiences. I am using my training and education in the expressive arts to support the declaration that the use of a multimodal trauma informed approach to group therapy in the psychiatric setting has the potential to increase group cohesion.

Method

The "Hope Notes" directive was created as an opportunity for clients during inpatient hospitalizations to create a collaborative art piece and promote unit cohesion within the group setting. The method was developed after several months of observation and training in hospital protocol from rehabilitation staff and unit staff including social workers, mental health counselors, nurses, and psychiatrists.

Participants

The Hope Notes directive was implemented on three locked inpatient units and one partial hospitalization unit of a psychiatric hospital in Boston, Massachusetts. Those on inpatient units carried diagnoses including, but not limited to schizophrenia, bipolar I, bipolar II, major depression, borderline personality disorder, substance use disorder, and psychosis. Often patients' histories also included suicidal and/or homicidal ideation, at least one reported traumatic incident in their lifetime, and a high percentage of homelessness. The duration of hospital stays varied from 1 day to 2 months and the age range included individuals 13 to 65 years old. Daily structure for those in this hospital included a full day of groups facilitated by a variety of staff, including nurses, social workers, and mental health counselors; frequent outdoor breaks; scheduled down time; and, three meals per day.

While no clients were required to attend any groups, they were made aware during intake and treatment plan meetings that they were expected to attend as many groups as possible as part of treatment. On each unit the group room also doubled at the unit kitchen for clients to use; however, during groups the kitchen was closed in order to promote a focused therapeutic environment. In addition, each group room was equipped with several tables and chairs which further aided in group cohesion as the facilitator and group members sat around the tables together if a client chose to join.

Unit Dynamics and Challenges

The Rehabilitation Department, in which I was a member, was composed of expressive arts therapists and occupational therapists that traveled to each unit for groups which lasted either 40 or 45-minutes dependent on unit schedules. Patients for this intervention were each invited to participate in the group based on hospital treatment plan protocol, however, no patients were required to attend at any point. One challenge that existed for the Rehabilitation Department

included group dynamics on each unit. Because our team was not housed on one unit for an entire day, we were required to enter a space, obtain any pertinent client information from unit staff about those who were, or were not, group appropriate at the time, and facilitate a group. This provided a challenge for me as an intern, because the expectation was to facilitate a minimum of four groups per day, and the constant adjustment and readjustment took time and practice. Some days I would facilitate a group on our adolescent unit in the morning with a select group of individuals with a dynamic for that hour then return in the afternoon to a completely different set of people and a completely altered dynamic. Often the dynamic of a group was impacted by clients taking prescribed medications during the day, having meetings with the unit doctor, meeting with any visitors that arrived during visitation hours, clients being discharged, or new clients arriving to the unit.

With the consistently shifting group dynamic on each unit the expectation of the Rehabilitation staff is to arrive to a unit with a group in mind and all the supplies necessary to facilitate said group. However, after receiving the debriefing from unit staff it may be necessary to alter or adapt the directive in the best interest of the clients present. Any directive brought to a unit including scissors needed to be approved by unit staff prior to use in case there was a safety concern for clients or staff. In addition, any directive was required to include adaptable concepts for the variety of levels of functioning in each group. For example, if the group was designed to discuss meditation and the present group members appear to be experiencing hallucinations or delusions it was often in the best interest of the clients to attempt a more concrete directive such as working with visual art.

Group Procedure and Materials

Materials required for this directive included: construction paper cut into strips (1-inch thick) with a variety of colors, marker, colored pencils, gel pens, multiple glue sticks, music player, small speaker, and sample piece to demonstrate. The protocol for this directive was a multimodal approach where we all sat around a table and began as a group by introducing ourselves and sharing a response to a check-in question. This multimodal approach was chosen as a method of trauma-informed care to attend to the *window of tolerance* for any client present in group (Perryman, Blisard, & Moss, 2019). In addition, a check-in question was posed before each session as required by hospital group protocol. I had the opportunity to cater the check-in question to my group topic, and decided to ask similar questions each group in order to assess if the check-in appeared to have any impact on the course of the group. Typically, the check-in question was dependent on the energy of the group, however, for consistency I asked one of two questions. For a higher energy group that appeared to be socially engaging as the group formed, I chose to ask "What is one piece of advice someone gave you that still matters to you today?". Alternatively, for lower energy groups possibly evidenced by silence at the start of group I began with "What is one thing you are proud of?". Once each group member responded to the check-in question (first 10 minutes of group) the content of the directive was introduced including showing a small example made by myself (three paper slips in three different colors decorated with words and images, all connected in loops). Paper loops were chosen for this directive to ensure accessibility for each unit of the hospital. The rehabilitation staff are required to transport materials across the property and using construction paper slips to build the pieces allowed for easy transportation and accessibility for staff and clients.

Phrases used to explain the directive included:

A quote that inspired this group was “be the person you needed when you were younger” (Ayesha Siddiqi, 2013) and the idea that came from it follows. Together we are going to create a collaborative piece that will be on display for your own unit. I challenge each of you to choose one piece of paper at minimum and decorate it using words, phrases, images, or colors that may provide inspiration for others. After choosing a paper each client will be provided the option of markers, colored pencils, or gel pens to decorate their paper strip with the question: What hope do you have for yourself? For today? For tomorrow? For this month? Once you have come to a pause with one piece you may decide to create another or collaborate with other group members to combine the pieces.

Clients were allowed between 20 to 25 minutes to work on decorating their paper slip with soft music playing in the room from a small speaker. Only wordless music was played and dependent on the energy of the group some quiet conversation was allowed. Once it appeared that collectively clients had come to a pause after approximately 20 to 25 minutes the group was opened for discussion of their art. Clients were welcome to share the advice, images, or hopes they chose to use for display.

The final step of the protocol is to transition from discussion into action for the final 10 to 15 minutes and have each client advocate for where they want their piece displayed in the collective design. A short demonstration was made during each group for gluing technique and with the help of the facilitator the group would decide how to connect their paper strips, in what order, and where specifically they wanted it displayed. Once all pieces were added to the collective the larger piece was held for clients to observe before placing it on display for the unit as the close of the group.

The process of connecting each piece and working as a group to collaborate was decided intentionally as part of the development of group cohesion. In order for each client to participate and engage in the group fully they were not only asked to work independently they were also asked to be a member of our small community, and share their opinion. This community building process was designed to increase group cohesion on the unit and provide a common goal for all clients. Finally, the process of collaborating to build a piece of art together for display on the unit was a representation of their time and framed as an opportunity to give back to the unit.

Responding to Resistance

After months of observation and training with the Rehabilitation Department I learned multiple forms of redirection for resistance in clients. The first line of resistance to appear typically came from clients not wanting to participate in the group or even enter the group room. Generally, conversations with these clients had three outcomes: the client expressed hesitation but joined the group under the impression that we are only looking for them to try as part of treatment, the client expressed conflicting feelings about wanting to try and wanting to be alone and they were invited to wait a few minutes before joining the group, or they vehemently reject the idea of group and were encouraged to try another group later in the day when they felt ready to participate in their own treatment.

Regularly in groups clients will mention that they are not an artist, or they have no talent for art. It has appeared transformative to observe individuals who come from task-based backgrounds to engage with themselves creatively. It has also been observed in groups when one person mentions they are not an artist, several other members appear to be comfortable making similar statements, beginning the process of group cohesion through common ground.

Other variations of resistance appeared for clients during group participation. Clients would share that they were stuck and did not know what to draw or write. Other times they might throw away piece after piece until seemingly satisfied with a product. The general response to resistance during the creation process was to sit with the client and share observations of their experience such as "I have noticed you got rid of several pieces" or "You appear to be thinking of what to work on at the moment." The phrases often initiated conversations with clients and gave them the opportunity to express their thought processes. Prompting questions were also used when participants appeared stuck after sharing observations such as "What is one thing someone says to make you feel better?", "What images or colors give you hope and how do you want to share them?", or "What advice would you give to another client that arrived to the unit today?". Often these prompting questions were heard by multiple group members and allowed for conversations to begin about their own experiences which aided the group cohesion process.

Documentation and Responses

At my internship site the hospital documentation policy is required to show how each client either participated or declined groups. During the group, staff members keep notes of participation and after each group every client has a file in which group participation is recorded. Notable information includes any insights shared during the group, level and type of participation (active or passive), how the client interacted with others, and observations of behavior. Because unit staff are not allowed into groups facilitated by the Rehabilitation Team it is also a necessary step to verbally share any pertinent information disclosed during group that may directly impact client safety and care.

After each facilitation of the directive I engaged in my own artistic response. This included working in my altered book (photos of altered booking in Appendix), communicating with staff in the supervisory relationship as a sounding board, or spending time reflecting about the process after each group. The opportunity to engage in artistic reflection aids in the expressive arts process as I attempt to facilitate cohesion between clients on each unit.

Results

This section will describe the sessions on different units as well as my observations, reflections, and communication with other Rehabilitation Team Members. I will also analyze what was is like to facilitate this protocol on each unit and the differences with each facilitation per the various group dynamics. The age range of those who engaged in the directive was 13-65 on four separate units, including three inpatient and one adult partial-hospitalization unit. In addition, of the three inpatient units one housed adolescents and two housed adults. While it is notable that each unit was unique there appeared to be consistent themes to appear with each regardless of location or group dynamic.

Session 1: Unit A, Adolescent Inpatient

Observations. (Four Clients) Introducing the directive for the first time ever was a combination of stressful and exciting. It was also the first group that I was able to facilitate without another rehabilitation staff member. The four individuals that were in the group were open to the check in question of "What is something you are proud of?". After answering the check in question, the directive was explained with no questions from the members; however, one individual decided to leave group without providing a reason and did not return before the end of group. During creation and construction soft instrumental music with nature sounds was provided for the group via a small speaker and iPod. Each member that remained for the

duration of group (three) made multiple pieces including quotes, motivational phrases, and images. The clients worked on deciding together what order to link the papers to each other appropriately. The group discussion was open ended during the creation process and became about money and what the world looked like without it including what each person would do if money did not matter. After this topic was discussed by each member everyone also shared what profession they were interested in or were taking classes for and what kind of college they were looking to attend in the future. It appeared as if each member was fully attentive to the other and provided supporting statements. I asked the group to pause the topic of discussion so we could finalize design choices for the piece and glue together all paper strips that were connected to each other for a chain-like shape. During wrap-up I held the piece for all members to observe what they had created together, invited each to read what they had written or share what was drawn. The final question of group was an inquiry of how the group felt to each person. Each member shared a one-word response and the group was then brought to a close.

Expressive arts response. My primary response to the first facilitation of this method was displayed in the opportunity to process with other rehabilitation staff. Those who were available acted as a sounding board and asked what my feeling was after my first attempt. I shared that I was, in a sense, relieved to have one round under my belt. In another sense I was relieved that the clients appeared to understand and absorb the directive based on their art responses added to the final product. Verbal processing time was limited after the initial session as it was then time to transition to a different unit and attempt the directive with a group on an adult inpatient unit. A similar rush of nerves flowed over me as I braced myself to potentially have a much different outcome from the adult group.

Session 2: Unit B, Adult Inpatient

Observations. (Four Clients) The same check-in question was used: What are you proud of? Each person shared they were either proud of themselves or a family member which lent itself to the theme of people rather than ideas. Once the directive was shared clients each appropriately asked for assistance from myself and from each other regarding what to draw or write on their paper slip. As previously reported the prompting questions were used to either promote discussion and the creative process for each client. Soft instrumental music with nature sounds was provided for the group via a small speaker and iPod. The group worked quietly and independently after each decided on what to use for their individual piece or pieces and one topic that arose was that of children. Many members of the group had children and it appeared to be a connecting factor for them to each discuss what it was like having children and their hopes for the future. It was enlightening to see the clients share not only about their own experience, but how sharing with the group allowed them to get to know each other better. We worked together to decide which pieces could connect to another and collaboratively designed the chain shape. The final decision to be made as a group was a display location for the piece on the unit, and once a location was chosen we closed the group by each sharing how we felt after making art together. Responses from the adult group were generally positive with themes of happiness, relaxation, and connection.

Expressive arts response. With more time for processing after the second group facilitation I found myself asking many questions. It felt as if the questions along with a feeling of accomplishment were buzzing in my mind as depicted in my art response, as seen in Figure 1, found in the Appendix. In the first two sessions clients appeared to ask similar questions which made me question the specifications of the directive and my delivery. For example, where could I have been clearer? How can I adapt the directive in the future to reduce client hesitation?

Generally, the art response is focused on my interaction with the facilitation process rather than the observed process of the clients. It is possible, however, that the art response reflecting my internal process may have been a witnessing of the client's process. I observed each person sit with their ideas, grapple with choosing, then finally decide, and for those in a psychiatric hospitalization such a directive could have been seen as a monumental task.

Session 3: Unit C, Adult Inpatient

Observations. (Nine Clients) Using the same check-in, "What are you proud of?". This group was a bit more hectic than the two previous, as multiple clients elected to observe rather than actively participate through art making. Most people answered themselves, a sibling, or their children. Soft instrumental music with nature sounds was provided for the group via a small speaker and iPod. Explaining the directive generally took longer as questions came in from clients during instructions. One observation I made was that of the sample piece brought to groups. I displayed my example/sample of only three loops for each group prior; however, this was the first time a client directly copied the work I showed. This was also the first group with a notably wide range of intellectual functioning, and it was a group effort to keep everyone focused to the best of their ability, as well as make sure everyone understood. We worked together to decide what order to make connections and the shape became non-linear (recommended by a client who had been in active psychosis, reported by staff, and displayed disorganized behaviors for the duration of the week prior to group). The shape of the connections became similar to a *tree* rather than a linear pattern. When asked why we would bring this idea to a group, responses reflected themes of: connection, communication, expression, and fun. We closed the group with a discussion about what it means to come to group and express yourself.

Expressive Arts Response. My artistic reflection of this group is evidenced by the use of trees in the foreground as seen in Figure 2, found in Appendix. An additional theme that became clear in the art was the mountainous or uphill climb toward a goal. This particular group required a significant amount of redirection and maintained a high energy for the duration and as the facilitator I observed myself wavering in energy and pushing forward to support the group. The additional imagery of the mountain is a reflection of the group process, and the observed note that each group member supported each other throughout the process.

Session 4: Unit D, Adult Partial Program

Observations. (Seven Clients) With the check-in "What is the best or worst piece of advice someone has given you?" This particular check-in question was altered from previous groups due to the depth and reflection in answers expected daily from those in the partial program. Each client shared a piece of advice and the directive was shared with the group including the provided small example. One client who had shared about her depression began sharing quotes from a comedic film listed off of their phone, which consistently made the whole group laugh. One member shared that the time in group helped her feel more comfortable on her first day at the program and referenced the client sharing film quotes specifically for helping her feel better. The group appeared to have a direct impact on cohesion of the partial unit at that time evidenced by the direct conversations with the entire group during check out related to the theme of connectedness. Together the group constructed their collaborative piece and decided where to put it on display.

Expressive Arts Response. My artistic response to this group arrived spontaneously during a processing conversation with my expressive arts supervisor who was present during the group at the adult partial program. I was given the opportunity to share a sound and movement

capturing my response to the group and it can be described as holding both arms above my head with hands clenched in fists, face turned toward the ceiling, smiling, and letting out a heavy sigh of relief. The anticipation of leading the directive with my supervisor present was challenging and also propelled me to ensure my instructions were as clear as possible while remaining open-ended. The observation of each client supporting each other through laughter and finding the words to share how specifically they supported each other during the day after making art was a clear example of the themes of connectedness and group cohesion.

Session 5: Unit A, Adolescent Inpatient

Observations. (4 Clients) With the check-in, "What are you proud of?", each responded that they were proud of themselves. Soft instrumental music with nature sounds was provided for the group via a small speaker and iPod. Each client made at least one note including phrases on topics such as; beauty, starlight, and attending groups. In the middle of group a conversation started with two remaining clients about their pride in themselves for remaining in group. Two clients had left previously for unstated reasons and did not return to the group. The two remaining clients appropriately collaborated to connect all notes together and were able to appropriately communicate that they were unable to remain in group any longer due to reported anxious symptoms and were dismissed.

Expressive Arts Response. During the fifth session of facilitating this directive it appeared that clients were comfortable collaborating even in small settings. This particular group began with only four participants and by the end two remained to complete the task together. From a product perspective the final piece contained as much if not more detail compared to previous groups with a larger number of participants. It appeared as if the group time allowed the two young female clients who remained in group to deepen the relationship

they had developed over the course of several days on the unit together based on questions asked of each other and compliments of each other's art during the creation process. My art response to this group using my altered book is Figure 3, located in the Appendix.

Session 6: Unit B, Adult Inpatient

Observations. (Seven Clients) The group also began with the check-in question "What are you proud of?"; and, every person answered with a family member or significant other. After explaining the directive and showing an example of a piece that was still on the unit from a previous group each member was challenged to make at least one to either add to the original or make their own as a group. This was another example of a group containing a seemingly wide range of intellectual functioning. Challenges occurred when the directive was not clear to several group members as evidenced by receiving several questions about instructions and multiple occurrences of required clarification. Each group member made at least one piece; however, each member was not willing to contribute the piece to the collaborative work and decided to keep their work. With a large amount of facilitation, prompting, and encouragement (compared to previous groups) the pieces were connected. In closing, when the group was asked why we would bother making a piece together their answers were related to themes of connection and expression.

Expressive Arts Response. With the sixth turn to facilitate this directive I still found times when instructions appeared unclear to clients, as well as resistance to the collaboration process during group. This particular facilitation required a significant amount of intervention from myself to promote communication between each client. The unit on this particular day during this particular time did not appear interested in demonstrating connection through art of their own accord. However, at the end of group when the pieces that were designated to be part

of the collaborative piece were all combined the reactions of the group appeared to contain surprise and pride. The contrast of resistance during the group process and pride during the closing presentation seemed stark as a facilitator; however, the opportunity to hear client's answers related to expression and connection allowed me to see that the focus of the group had been identified. My art response to this group using my altered book is Figure 4, located in the Appendix.

Session 7: Unit A, Adolescent Inpatient

Observations. (Three Clients) The group began with the check in question "What are you proud of?" and each person answered with a family member including parents. There appeared to be a bit of teasing between clients for their answers and this was redirected so each person was still able to give an answer regardless of other's reactions toward the answer. Once the check in question was finished each member was also challenged to add at least one paper to the collaborative piece made during a previous group (session five) on the same unit. They were shown what other individuals had made 11 days before, and no member of the current group (session seven) participated in the previous group on this unit (session five). Each client contributed at least one piece and an additional Rehab Staff member brought his guitar to the group to play as pieces were created. Rather than playing nature music as was done in previous facilitations the additional staff member offered to have each client present the advice they wrote about and he would use them to make a song. This incentive appeared to allow the clients the challenge to make more pieces to challenge the staff member in the process of improvisational songwriting based on the words written on each piece they added. In total the clients created 16 pieces together and appeared proud of their work during check-out as evidenced by their body language and verbal reactions to seeing the larger collaborative piece. When asked "Why would

we do this group?" the responses were related to themes of: motivation of self, motivation of others, creativity, connections, and making art.

Expressive Arts Response. The final facilitation of Hope Notes allowed for the opportunity to collaborate with another expressive arts therapist. Because this staff member brought their guitar and improvisational songwriting skill to the group it appeared to lift hesitations or resistance that existed in previous groups. In addition, bringing a piece that had previously been created by a separate group of teens from the same unit may have had an impact on the approach for the final group of adolescents. These two details combined appeared to directly impact the course of the group as well as provide a deeper multi-modal experience found in expressive arts therapy. The art response as seen in Figure 5, found in Appendix depicts the intermodal weaving of the therapeutic process and the experience of witnessing as well as facilitating Hope Notes.

Discussion

The Hope Notes directive was created as an opportunity for clients to participate in during inpatient hospitalizations by creating a collaborative art piece and promoting unit cohesion through visual art.

Observed Themes

Several themes were observed during the several iterations of the directive including clients sharing their reactions to the group time together. Themes that were presented included: family, connection, expression, relaxation, communication, and motivation. Each of these themes and key words used to summarize client responses to the directive are evidence to the fact that they were invested in the process and therefore invested in the social connectedness aspect of the group. Each member not only was invited to participate in creating their own art

and reflective piece, but also collaborate with others in the group to make one piece with everyone's work and the shared themes. Client responses echoed those shared by Teglbjaerg (2011), "I have learned to know others in a way I never could have learned to know somebody else, through the art" (p. 316). It is through my observations of the group sessions that it appeared that clients benefited from the collaborative group process and the act promoted group cohesion for the unit.

Limitations

Limitations of this study include the focus on strictly observational and experiential data. While working within the medical model it can be challenging to bring in observational data as a comparison to a treatment plan; however, in my experience bringing my observations to the doctors on each unit assisted in deciding the next steps for clients in regard to their recovery. A second limitation to this study is the optional participation in groups. While this provides the opportunity to work with those who are motivated or understand the role of group therapy it also leaves out those who choose not to go to group at that time of day.

Future Research

One idea for future research with this directive is to consistently include the use of a songwriting element before the construction period, as was done during the final reported group. There is also a significant amount of research to be done about the role of the expressive arts in and outside of the psychiatric setting; however, I believe that Hope Notes is a solid foundation on which to build that research.

Conclusion

After facilitating the Hope Notes directive, a minimum of 10 times on inpatient and partial hospitalization units at a private psychiatric hospital, my observations lead me to believe

that creating a collaborative art piece using expressive arts therapy helps to promote a sense of connection, community, and cohesion through the group process.

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Appendix

Art Reflections

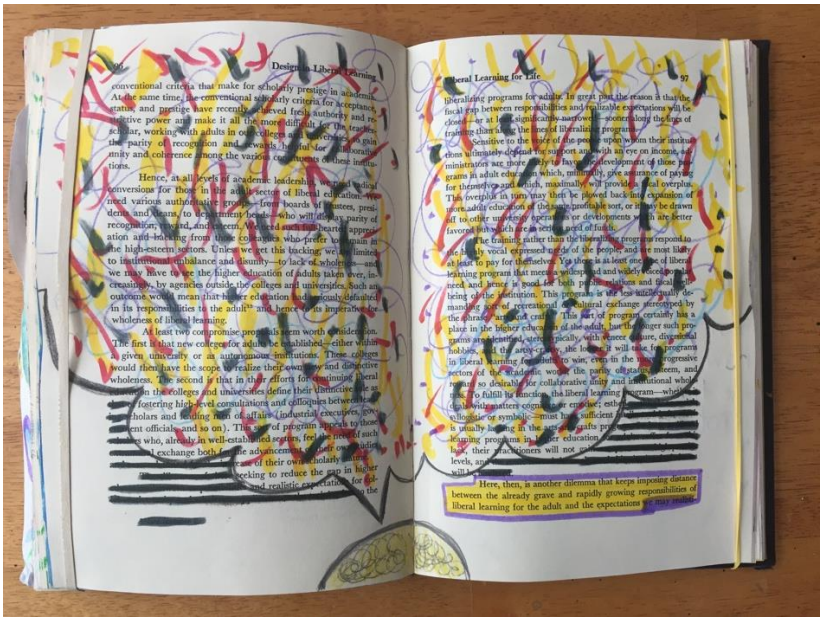

Figure 1: Formulating

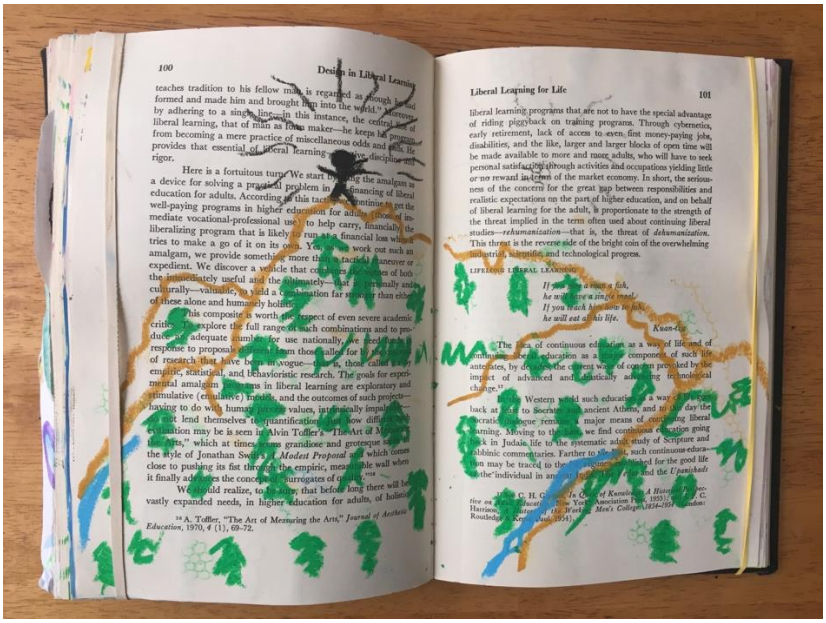

Figure 2: Finding preliminary success

Figure 3: The transformation and growth

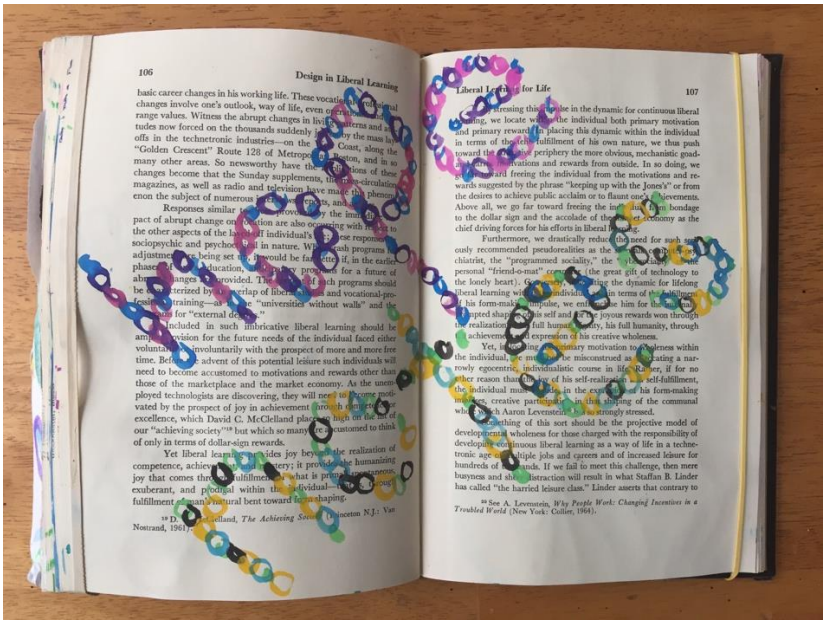

Figure 4: Formalizing and taking ownership

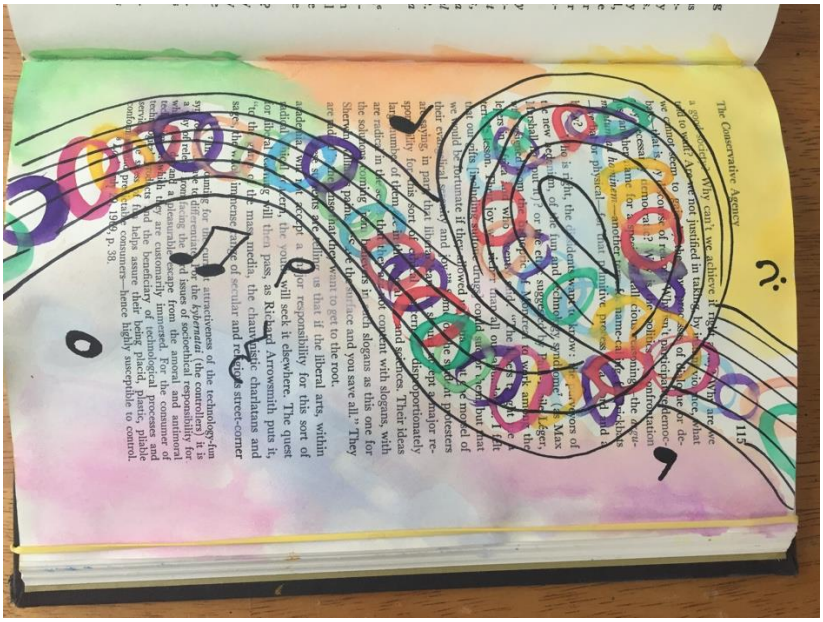

Figure 5: The power of collaboration and future considerations

THESIS APPROVAL FORM

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Student's Name: Mariah L. Logan

Type of Project: Thesis

Title: "There was something magical about this group": Building Cohesion in a Psychiatric Hospital.

Date of Graduation: May 18, 2019

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Donna C. Owens, PhD